

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2953

153

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty KentRegistration Dist. No. 201Village or City Morgan Neck (No. Kennedyville 2) St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]2 FULL NAME Spencer Raymond Bard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Cal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Feb 20, 1914
(Month) (Day) (Year)

7 AGE 7 yrs. 9 mos. 9 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Kent Comd

10 NAME OF FATHER John Bard

11 BIRTHPLACE OF FATHER (State or country) Kent Co.

12 MAIDEN NAME OF MOTHER Sadie Taylor

13 BIRTHPLACE OF MOTHER (State or country) Kent Comd

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sadie Taylor(Address) Kennedyville 2

15 Filed Mar 30, 1914 William Parr
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from no medical attention to 29

that I last saw him alive on _____, 1914

and that death occurred on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Injury from defective
feeding
(Duration) yrs. 1 mos. 9 ds.

Contributory Neglect
Secondary _____

(Signed) Frankie L. Smith M. D.

Chesapeake
(Address) _____, 1914

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Morgan Neck Comd DATE OF BURIAL March 31, 1914

20 UNDERTAKER Chas L. Dodd ADDRESS Chesapeake

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

County Kent.

2954

91

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 202Village or City Buttletown (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Marythelma Boston

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH April 29, 1914
(Month) (Day) (Year)

7 AGE 34 yrs. 10 mos. 10 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9 BIRTHPLACE (State or country) Oklahoma

10 NAME OF FATHER John Cook

11 BIRTHPLACE OF FATHER (State or country) Charleston S.C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James M. Boston(Address) Worton Md.

15 Filed Mar 14, 1914 W. H. Hicks
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from march 5, 1914, to march 8, 1914
that I last saw her alive on march 8, 1914

and that death occurred on the date stated above, at 4:20 A. M.
The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Bronchopneumonia

(Signed) L. P. Atwell, M. D.
3-10, 1914 (Address) Still Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Baltimore Md DATE OF BURIAL March 13, 1914

20 UNDERTAKER Charles L. Dodd ADDRESS Buttletown Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative deathfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state *WARS* or *INJURY* and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 2 1914
BUREAU, U. S.

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1 PLACE OF DEATH 2955
 County Kent
 Village or City Buttontown (No. Horton 3. St.; Ward)
 2 FULL NAME Percy Edward Butler
 Registration Dist. No. 202
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 4 COLOR OR RACE ca
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
 (Write the words)
 6 DATE OF BIRTH Dec. 6, 1895
 (Month) (Day) (Year)

7 AGE 18 yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Farmer laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kent Co. Md.

PARENTS
 10 NAME OF FATHER George Andrew Butler
 11 BIRTHPLACE OF FATHER (State or country) Kent Co. Md.
 12 MAIDEN NAME OF MOTHER Caroline Scott
 13 BIRTHPLACE OF MOTHER (State or country) Kent Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Caroline Scott
 (Address) Horton 2.

15 Filed Mar. 26, 1914 W. F. Hicks
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 27, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1914 to March 26, 1914,
 that I last saw him alive on March 26, 1914

and that death occurred on the date stated above, at 9 1/2 m.
 The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 0 mos. 0 ds.
 Contributory General Fatigue
 Secondary

(Duration) 1 yrs. 0 mos. 0 ds.
 (Signed) Franklin Smith, M. D.
March 27, 1914 (Address) Chesapeake and

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Buttontown Md Mar. 29, 1914
 20 UNDERTAKER ADDRESS
W. F. Hicks Chesapeake and

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2856

County

Kent

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

202

Village or City

Chestertown

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Iris Brown Chambers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Apr 9

(Month)

(Day)

1913
(Year)

7 AGE

1 yrs. 6 mos. 13 ds.

(Year)

If LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Infant

(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Kent Co Md

PARENTS

10 NAME OF
FATHER

Iris Brown Chambers

11 BIRTHPLACE
OF FATHER
(State or country)

Md

12 MAIDEN NAME
OF MOTHER

Ella Brown

13 BIRTHPLACE
OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Iris Brown Chambers

(Address)

Chestertown Md

15

Filed Mar. 22, 1914

W. F. Nicks

LOCAL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mch 22

(Month)

(Day)

1914
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Berk

1913

to

Jun 31

1914

that I last saw him alive on

Jun 31

1914

and that death occurred on the date stated above, at

6 am

The CAUSE OF DEATH* was as follows:

Rachitis

Contributory
(Secondary)

Heredity

(Signed)

H. Benge Simpson M. D.

Mch 22

1914

(Address)

Chestertown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

It not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jones M. E. Cam

Mar 24, 1914

20 UNDERTAKER

ADDRESS

J. E. Ferguson

Chestertown

1

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

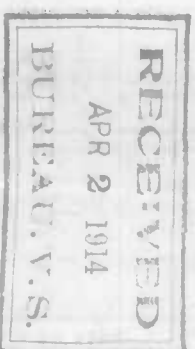
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH

County

Kent

2957

(151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

201

Village or City

Dutchtown

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Bratcher Chambers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

*Black*5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)*single*

6 DATE OF BIRTH

*Mar**27**1914*

(Month)

(Day)

(Year)

7 AGE

—

yrs.

mos.

3

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)*Kent Co Md*

PARENTS

10 NAME OF FATHER

*John Chambers*11 BIRTHPLACE OF FATHER
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Bratcher*13 BIRTHPLACE OF MOTHER
(State or country)*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt Bratcher

(Address)

Still Pond Md

15

Filed

*Mar 31**1914**William Parr*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*3**30**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191...., to

191....

that I last saw him alive on *3-28*, 191*X*and that death occurred on the date stated above, at *P.m.*

The CAUSE OF DEATH* was as follows:

Immature birth

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)*Immature birth*

(Duration)

yrs.

mos.

ds.

(Signed)

L. P. Alwell

, M. D.

3-31, 191*4*

(Address)

Still Pond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mes.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Magnolia M. E. Church**Mar 31, 1914*

20 UNDERTAKER

ADDRESS

*W. H. Kousen**Still Pond*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

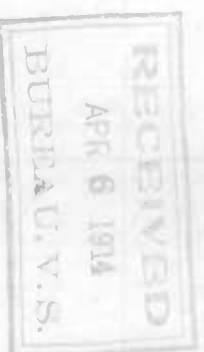
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative *deathfulness* of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Kent Co Md

2958

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

200

Village or City

near Chesterville

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lillian A. Chavis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*married*

6 DATE OF BIRTH

July 4, 1829
(Month) (Day) (Year)

7 AGE

84 yrs. 8 mos. 20 ds.
If LESS than 1 day, hrs. OR mo.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)*Lucien Anna Co*

10 NAME OF FATHER

Robert Lore

PARENTS

11 BIRTHPLACE
OF FATHER
(State or country)*Maryland*12 MAIDEN NAME
OF MOTHER*Unknown*13 BIRTHPLACE
OF MOTHER
(State or country)*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant)

Lillian A. Chavis

(Address)

Crumpton Ind

15

APR 2 - 1914
Filed*Julian J. Jones*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar. 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Mar. 20, 1914, to Mar. 24, 1914,*that I last saw him alive on *Mar. 24, 1914,*and that death occurred on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) yrs. mos. *7* ds.Contributory
(Secondary)*Exhaustion*

(Duration) yrs. mos. ds.

(Signed)

Arthur S. Lander, M. D.*Mar. 191* (Address) *Crumpton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Crumpton Cemetery**Mar 27, 1914*

20 UNDERTAKER

ADDRESS

Bradley & Sparks Crumpton Ind

1

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

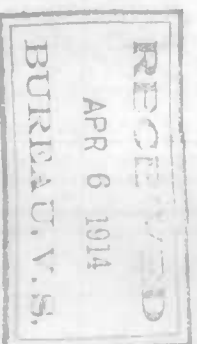
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Kent

2959

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *202*

Village or City

Chestertown

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Daniel Poca Cox

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

June 19, 1835
(Month) (Day) (Year)

7 AGE

78 yrs. *9* mos. *12* ds. *OR* LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Blacksmith

9 BIRTHPLACE

(State or country)

New Jersey

PARENTS

10 NAME OF FATHER

Daniel Cox

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Caziah Baylor

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Daniel Cox

(Address)

Chestertown

15

Filed

April 2, 1914
W. T. Hicks
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 31, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sudden to death, 1914
that I last saw him alive on *medical attention* 1914and that death occurred on the date stated above, at *7* m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

Contributory
Secondary*Sudden*

(Duration) yrs. mos. ds.

(Signed)

Francis Smith M. D.
Nov. 31, 1913 (Address) *Chestertown*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chestertown *Chestertown* *April 3, 1914*

20 UNDERTAKER

ADDRESS

Chas. L. Dodd *Chestertown*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

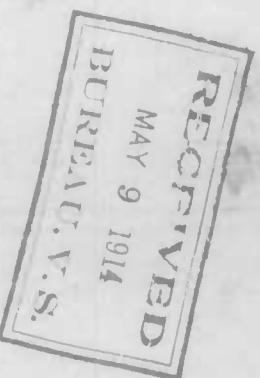
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2960

5

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty KentRegistration Dist. No. 203Village or City Rock Hall (No. _____, _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(Still-Born)Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED none
(Write the word)

6 DATE OF BIRTH

March 10, 1914
(Month) (Day) (Year)

7 AGE

____ yrs. ____ mos. ____ ds.

If LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Rock Hall, Md.

PARENTS

10 NAME OF FATHER

Geo. Henry Davis11 BIRTHPLACE OF FATHER
(State or country)Rock Hall, Md.

12 MAIDEN NAME OF MOTHER

Rhoda Downey13 BIRTHPLACE OF MOTHER
(State or country)Rock Hall

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. H. Davis

(Address)

Rock Hall

15

Filed

3/101914T. B. Durdning

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 10, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

____, 191____, to ____., 191____.

that I last saw him alive on ____., 191____.

and that death occurred on the date stated above, at ____m.

The CAUSE OF DEATH* was as follows:

Still-Born

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) T. B. Durdning Registrar

____, 191____ (Address) _____

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. to the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wesley Chapel Cem.3/10, 1914

20 UNDERTAKER

ADDRESS

Geo. H. DavisRock HallMd.

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Sent out for Locals' signature, original signed by a midwife

RECEIVED
JUN 11 1914
BUREAU. V. S.

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 2 1914
BUREAU. V. S.

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1 PLACE OF DEATH
County Kent 2961

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 200

Village or City Massey (No. _____, St; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Arthur Ford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 10, 1876
(Month) (Day) (Year)

7 AGE 37 yrs. 7 mos. 24 ds. It LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Stephen Hyland Ford

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Lenette Ann Ellison

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Lavinia Ford

(Address) Massey Md.

15 MAR 8 - 1914
Filed 1 1914 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1913, to March 6, 1914, that I last saw him alive on March 6, 1914

and that death occurred on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) Indefinite yrs. ____ mos. ____ ds.
Contributory (Secondary) Intestinal Hemorrhage
(Duration) ____ yrs. ____ mos. 9 ds.

(Signed) Geo. W. Jones, M. D.
March 7, 1914 (Address) Galena Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Earlville Md. DATE OF BURIAL March 9, 1914

20 UNDERTAKER John L. Smith ADDRESS Mullingtown Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septiciæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2962

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Village or City

Registration Dist. No.

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Boy

4 COLOR OR RACE

colored

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

March

6th

(Month)

(Day)

(Year)

7 AGE

still born,

If LESS than
1 day,.....hrs.

yrs.

mos.

ds.

OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Kent County

PARENTS

10 NAME OF
FATHER

Wm. Johnson

11 BIRTHPLACE
OF FATHER
(State or country)

Kent County

12 MAIDEN NAME
OF MOTHER

Katie Volley

13 BIRTHPLACE
OF MOTHER
(State or country)

Kent County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Johnson

(Address)

Parilee Kent County

15

Filed

Mar. 7

1914

J. M. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March

6

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on....., 191

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Brech. presentation

(Duration)

yrs.

mos.

ds.

(Signed)

B. W. Wheland

M. D.

March 6

1914

(Address)

Chesapeake

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. P. Mission

March

1914

20 UNDERTAKER

ADDRESS

Charles L. Dodd

Chesapeake

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

oma, Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | |
|--|---|---|---|--|
| 1 PLACE OF DEATH County <u>Kent</u> | | 2963 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Chelton</u> | | (No. <u>3</u>) | Registration Dist. No. <u>204</u> | |
| 2 FULL NAME <u>Mary Emma Jones</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>married</u> | | |
| 6 DATE OF BIRTH <u>July 9th</u> , 18 <u>69</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>44</u> yrs. <u>8</u> mos. <u>10</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Cecil Co. Md</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Mr Pennington</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Del</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Leath Hall</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Cecil Co Md</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. J. H. Keene</u> (Address) <u>Locust Grove, Cecil Co. Md</u> | | | | |
| 15 FILED <u>March 20</u> , 191 <u>4</u> <u>J. W. Smith</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>March 19</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>March 17</u> , 191 <u>4</u> , to <u>March 19</u> , 191 <u>4</u> , that I last saw her alive on <u>March 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5 P</u> m, The CAUSE OF DEATH* was as follows: <u>Angina Pectoris</u> | | | | |
| Contributory (Secondary) <u>None</u> | | | | |
| (Signed) <u>Frank W. Smith</u> , M. D. <u>March 19</u> , 191 <u>4</u> (Address) <u>Chelton</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Chestertown Md</u> DATE OF BURIAL <u>March 22</u> , 191 <u>4</u> | | | | |
| 20 UNDERTAKER <u>Lehas L. Dodd</u> ADDRESS <u>Chestertown</u> | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|---|---|-----------------------------------|---|---|
| 1 PLACE OF DEATH County <u>Kent</u> | | 2964 | 79 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Near Rock Hall</u> | | (No. <u>79</u>) | Registration Dist. No. <u>203</u> | | [It death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Lottie Kay</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>March 31, 1881</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>33</u> yrs. <u>11</u> mos. <u>21</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>House Keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Rock Hall, Md.</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Richard Grant</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Kent</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Rachel Linton</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Kent Co</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harry Kay</u> (Address) <u>Rock Hall RR #1</u> | | | | | |
| 15 Filed <u>3/23</u> , 1914 <u>T. B. Durdin</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>March 21, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY That I attended deceased from <u>March 8</u> , 1914, to <u>March 21</u> , 1914, that I last saw him alive on <u>March 21</u> , 1914, and that death occurred on the date stated above, at <u>9:30 a.m.</u> | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Heart Disease (Dilatation)</u> <u>Exhaustion</u> (Duration) yrs. mos. ds. | | | | | |
| Contributory (Secondary) (Duration) yrs. mos. ds. | | | | | |
| (Signed) <u>W. C. Kelly</u> , M. D. <u>March 21, 1914</u> (Address) <u>Rock Hall</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Wesley Chapel Cemetery</u> | | | | | DATE OF BURIAL <u>Mar 23</u> , 1914 |
| 20 UNDERTAKER <u>Thos A. Louey & Co Rock Hall</u> | | | | | ADDRESS |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2965

64

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Kent

Registration Dist. No.

200

Village or City

Millington

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Long

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

March

1st

1844

(Month)

(Day)

(Year)

7 AGE

70

yrs.

mos.

23

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farm labor

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Inda

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lia Robinson

(Address)

Millington Inda

15 MAR 26 1914

Filed

191

Julian J. Power

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March

24

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank Smith

, M. D.

3/26/1914. (Address) Fairlee Inda

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackstone Hotel

3/26

1914

20 UNDERTAKER

ADDRESS

John Smith Millington

If more blanks are needed, address State Registrar, C. E. Franklin St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

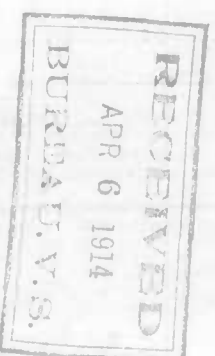
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary). *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2966

County

Kent

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

204

Village or City

Metitota

(No.)

Worton 1

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Unmarried Philborn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

col

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

March 25, 1914

7 AGE

Shelborn

If LESS than
1 day, hrs.
or mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Kent Co.

PARENTS

10 NAME OF
FATHER

William Mason

11 BIRTHPLACE
OF FATHER
(State or country)

Kent Co.

12 MAIDEN NAME
OF MOTHER

Rebecca Banners

13 BIRTHPLACE
OF MOTHER
(State or country)

Kent Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Pasin

(Address)

Worton 1

15

Filed March 25, 1914 J. N. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 25, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

no medical

that I last saw him alive on

Albion

and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Shelborn

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Frank W. Smith, M. D.

March 25, 1914 (Address) Chestertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Metitota

DATE OF BURIAL

March 27, 1914

20 UNDERTAKER

W. F. Hicks

ADDRESS

Chestertown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

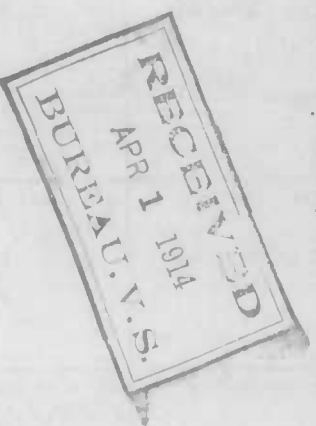
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Jaundice," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2967

(90) STATE OF MARYLAND
CERTIFICATE OF DEATH

County KentRegistered No. 200

Village or City

Galena

(No.)

St.

Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William J. Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

Feb.241824

(Month)

(Day)

(Year)

7 AGE

90

yrs.

mos.

7

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Kent County, Maryland

PARENTS

10 NAME OF FATHER

William J. Miller

11 BIRTHPLACE OF FATHER

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Lydian Elison

13 BIRTHPLACE OF MOTHER

(State or country)

Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sophie Miller

(Address)

Galena, Md.

15

MAR 3 - 1914

191

Julian, Doms

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March21914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

See

191

to

Feb 28 1914

191

that I last saw him alive on Feb 28 1914and that death occurred on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Serubility, chronic BronchitisAcute about 2 weeks (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edward A. Scott

M. D.

March 2, 1914 (Address) Galena, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Galena K. E. Ch. Yd.Mar 5, 1914

20 UNDERTAKER

ADDRESS

W. H. BrownStill Pond

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

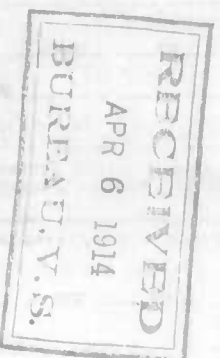
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | | |
|---|--|--|--|------------------------|--|---|--|
| 1 PLACE OF DEATH | | 2968 | | 154 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County | | Kent Near Rock Hall | | Registration Dist. No. | | 203 | |
| Village or City | | (No. _____) | | St.; _____ | | Ward) _____ | |
| 2 FULL NAME | | Anna E. Pearce | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | | | |
| Female | White | Widow | | | | | |
| 6 DATE OF BIRTH | | July 13, 1839 | | | | | |
| | | (Month) (Day) (Year) | | | | | |
| 7 AGE | | It LESS than 1 day, _____ hrs. 74 yrs. 7 mos. 20 ds. OR _____ min. ? | | | | | |
| 8 OCCUPATION | | Housewife | | | | | |
| (a) Trade, profession, or particular kind of work | | | | | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | |
| 9 BIRTHPLACE (State or country) | | Kent Co Md | | | | | |
| PARENTS | 10 NAME OF FATHER | Asha Sappington | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | Cecil Co Md. | | | | | |
| | 12 MAIDEN NAME OF MOTHER | Rosa Heareem | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | Cecil Co Md. | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | | |
| (Informant) | | Lillian Pearce | | | | | |
| (Address) | | 1 Rock Hall RFD | | | | | |
| 15 Filed | | 7/7 1914 T. B. Durdin | | | | | |
| | | REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH | | March 3rd, 1914 | | | | | |
| | | (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from | | Feb. 25th, 1914, to March 3rd, 1914 | | | | | |
| that I last saw her alive on | | March 3rd, 1914 | | | | | |
| and that death occurred on the date stated above, at | | 9-30 P. M. | | | | | |
| The CAUSE OF DEATH* was as follows: | | General debility Exhaustion | | | | | |
| | | (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| Contributory (Secondary) | | (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| (Signed) | | Walter O. Silby, M. D. | | | | | |
| | | March 5, 1914 (Address) Rock Hall, W. Va. | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | | |
| At place of death | | _____ yrs. _____ mos. _____ ds. | | In the State | | _____ yrs. _____ mos. _____ ds. | |
| Where was disease contracted, it not at place of death? | | | | | | | |
| Former or usual residence | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | DATE OF BURIAL | | | |
| Wiley Chapel K. Co. Md. | | | | March 7, 1914 | | | |
| 20 UNDERTAKER | | | | ADDRESS | | | |
| Chas. L. Dodd | | | | Chesertown | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

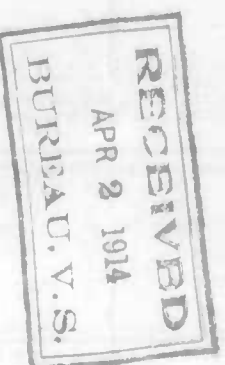
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 2969
County Kent

Village or City Millington (No. _____ St. _____ Ward _____)

2 FULL NAME George Louis Pipes

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept, 1832
(Month) (Day) (Year)

7 AGE 76 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer) Farm

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James Pipes

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Elliott

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George L. Pipes
(Address) Millington, Md.

15 MAR 14 1914
Filed 1914 John L. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1912, to March 13, 1914,

that I last saw him alive on March 13, 1914

and that death occurred on the date stated above, at 11 20 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. 4 mos. _____ ds.

Contributory (Secondary) Oedema of lungs

(Duration) _____ yrs. _____ mos. 2 ds.

(Signed) Herbert Bates, M. D.
3/14, 1914 (Address) Millington, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Millington 3-17, 1914

20 UNDERTAKER ADDRESS

John L. Smith Millington

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

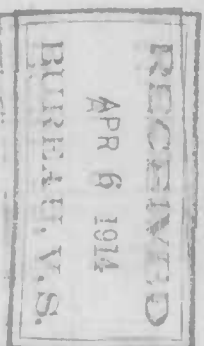
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(oil mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2970

County

Kent

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 202

Village or City

Chattanooga

(No.

Prospect

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Calvin Reed

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Cald

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

July 3

(Month)

(Day)

1912
(Year)

7 AGE

1 yrs. 8 mos. 1 ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Kent Co. Md.

PARENTS

10 NAME OF FATHER

Calvin Reed

11 BIRTHPLACE OF FATHER
(State or country)

Kent Co. Md.

12 MAIDEN NAME OF MOTHER

Mary A. Blake

13 BIRTHPLACE OF MOTHER
(State or country)

Kent Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Calvin Reed

(Address)

Chattanooga Md.

15

Filed

Mar. 4, 1914 W. H. Hicks

Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 27

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 20

1914

to March 27

1914

that I last saw him alive on March 27, 1914

and that death occurred on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 8 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. W. Whelan

March 27, 1914

(Address)

Chattanooga Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Chattanooga Md.

DATE OF BURIAL

March 27, 1914

20 UNDERTAKER

Charles L. Dodd

ADDRESS

Chattanooga

more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

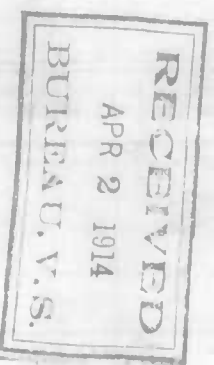
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 2971

County KentVillage or City Rock Hall (No. _____, _____ St.; _____ Ward)Registration Dist. No. 203

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(Still-Born)

Reed

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE black 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Mar. 16, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Rock Hall

PARENTS
10 NAME OF FATHER Jess Reed
11 BIRTHPLACE OF FATHER (State or country) Virginia
12 MAIDEN NAME OF MOTHER Rosa Lasten
13 BIRTHPLACE OF MOTHER (State or country) Rock Hall

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jess Reed

(Address)

Rock Hall, Md.

15 Filed 3/16, 1914 J. B. Durdin
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw h. _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still-Born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. B. Durdin Registrar
_____, 191____ (Address) _____

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Sharptown Cem. DATE OF BURIAL 3/16, 1914

20 UNDERTAKER Jess Reed (father) ADDRESS Rock Hall

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. & S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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JUN 11 1914
BUREAU. V. S.

oma, Sarcoma, etc., &..... (Name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

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*Sent out for local signature
first signed by a midwife*

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APR 2 1914
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|--|--|--|---|--|
| 1 PLACE OF DEATH | | 2972 | | STATE OF MARYLAND | |
| County <u>Kent</u> | | | | CERTIFICATE OF DEATH | |
| Village or City <u>Rock Hall</u> (No. _____) | | St.; _____ | | Ward _____ | |
| 2 FULL NAME <u>(Still-Born)</u> | | <u>Reed</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| Registration Dist. No. _____ | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>black</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>single</u> | | | |
| 6 DATE OF BIRTH <u>Mar. 16, 1914</u> (Month) (Day) (Year) | | | | | |
| 7 AGE _____ yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | | |
| 9 BIRTHPLACE (State or country) <u>Rock Hall, Md.</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Jess. Reed</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Rosa Laster</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Rock Hall, Md.</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jess. Reed</u> (Address) <u>Rock Hall, Md.</u> | | | | | |
| 15 Filled <u>3/16</u> , 191 <u>4</u> <u>T. B. Durdin</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>March 16, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____. | | | | | |
| that I last saw him _____ alive on _____, 191____. | | | | | |
| and that death occurred on the date stated above, at _____ m. | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Still-Born</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| Contributory _____ Secondary _____ | | | | | |
| (Signed) <u>T. B. Durdin</u> Registrar, No. _____ (Address) _____, 191____. | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Sharptown Cemetery</u> | | | | DATE OF BURIAL <u>3/16, 1914</u> | |
| 20 UNDERTAKER <u>Jess. Reed (father)</u> | | | | ADDRESS <u>Rock Hall Md.</u> | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

RECEIVED
JUN 11 1914
BUREAU, V. S.

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

*Sent out for local signature
first signed by a midwife*

RECEIVED
APR 2 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 2973
County Kent

Village or City Morgueck (No. _____) St.; _____ Ward)

2 FULL NAME

Hilda V. Ringgold

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 201

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Coed 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Dec 28, 1913
(Month) (Day) (Year)

7 AGE _____ yrs. 2 mos. 8 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country)

Kent Co Md.

10 NAME OF FATHER

Jos. L. Ringgold

11 BIRTHPLACE OF FATHER (State or country)

Kent Co Md.

12 MAIDEN NAME OF MOTHER

Marg. O. Stanley

13 BIRTHPLACE OF MOTHER (State or country)

Kent. Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Jos. L. Ringgold

(Address) Norton, K. Co. Md.

15

Filed Mar 5th, 1914 William Carr
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 6th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY: That I attended deceased from
March 4th, 1914, to _____, 191____
new that I last saw her alive on _____, 191____

and that death occurred on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:

From description of symptoms given by father. Pneumonia
(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary) Coed

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. Berge Simmons, M. D.
Md 6, 191____ (Address) Chestertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, it not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morgueck K Co Md March 7, 1914

20 UNDERTAKER ADDRESS

Chas. L. Dodd, Chestertown

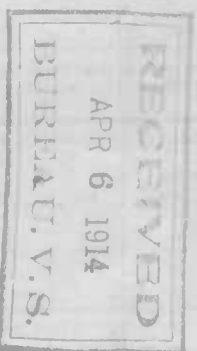
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (net paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary). *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, ~~or~~ homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

2974

County

Kent

Village or City

Fairlee

(No.)

Registration Dist. No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Elizabeth B. Stephens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

Nov 18, 1843

7 AGE

71 yrs. — mos. — ds. 1 LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Teacher retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore Md.

PARENTS

10 NAME OF FATHER

Wm. Bracham

11 BIRTHPLACE OF FATHER (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Kath. A. Richardson

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eda Stephens

(Address)

Chester town

15

Filed

March 6, 1914 F. N. Smith

REGISTRAR

1

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting Y. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 4, 1914

17

I HEREBY CERTIFY, that I attended deceased from

Nov 18, 1913 to March 4, 1914

that I last saw her alive on March 4, 1914

and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Contributory (Secondary)

Hemiplegia, Arterio-sclerosis (Duration) about 10 yrs.

(Signed)

Frank B. Hines, M.D.

March 5, 1914 (Address) Chester town Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Pauls Kent Co Md. March 8, 1914

20 UNDERTAKER

ADDRESS

Chas. L. Dodd, Chester town

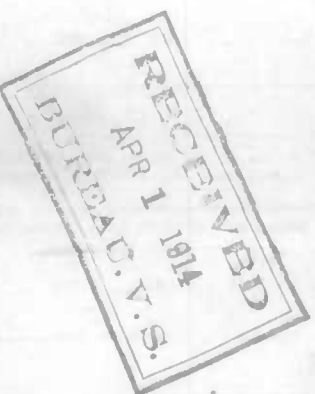
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2975

County

Kent

Village or City

Solts

(No.)

Registration Dist. No.

300

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Baby Siffitt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

S

6 DATE OF BIRTH

March 13, 1914

(Month)

(Day)

(Year)

7 AGE

X yrs.

X mos.

X ds.

If LESS than 1 day, X hrs. OR X min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Amos Siffitt

11 BIRTHPLACE OF FATHER (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Sally Bailey

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Miles M.D.

(Address)

Lonswood Del.

15

MAR 17 1914

Filed

1914

Julian D. Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 13, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1914 to March 13, 1914

that I last saw her alive on March 13, 1914

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Stillbirth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Miles

M. D.

March 16, 1914

(Address) Lonswood Del.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

..... yrs.

..... mos.

..... ds.

In the

State

..... yrs.

..... mos.

..... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Solts

March 16, 1914

20 UNDERTAKER

ADDRESS

None

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

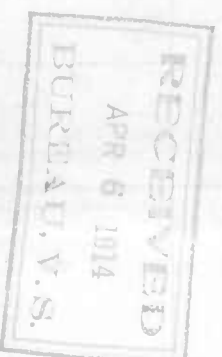
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanity," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 2976
County Kent

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

Village or City Millington (No. _____ St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Walter Franklin Tolson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 7 9 1869
(Month) (Day) (Year)

7 AGE 44 yrs. 8 mos. 8 ds. IF LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work General Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Quebec Anne Co

10 NAME OF FATHER John Merritt Tolson

11 BIRTHPLACE OF FATHER (State or country) not known

12 MAIDEN NAME OF MOTHER Leah B. Moss

13 BIRTHPLACE OF MOTHER (State or country) " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Harry Tolson

(Address) Phila Pa

15 MAR 19 1914 Julius D. Moore REGISTRAR
Filed 1 1914

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1914, to March 17, 1914, that I last saw him alive on March 17th, 1914

and that death occurred on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (Secondary) Acute Cardiac Dilatation

(Duration) _____ yrs. _____ mos. 2 hrs.

(Signed) J. Herbert Bates, M. D.

3/17, 1914 (Address) Millington Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Millington DATE OF BURIAL 3 20, 1914

20 UNDERTAKER John S. Smith ADDRESS Millington Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

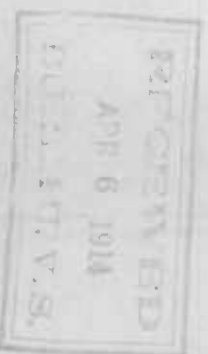
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(valuing, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name of organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH County <u>Kent</u> 2977 | | STATE OF MARYLAND CERTIFICATE OF DEATH 150 | |
| Village or City <u>Rock Hall</u> (No. <u> </u>) | | Registration Dist. No. <u>203</u> | |
| 2 FULL NAME <u>Robert-Edwood Urie</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Singel</u> (Write the word) | |
| 6 DATE OF BIRTH <u>March 4</u> , 1913 (Month) (Day) (Year) | | | |
| 7 AGE <u>1</u> yrs. <u>—</u> mos. <u>—</u> ds. | | If LESS than 1 day, <u>—</u> hrs. <u>—</u> min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> | | | |
| 9 BIRTHPLACE (State or country) <u>Kent Co. Ma.</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Charles R. Urie</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Kent Co. Ma.</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Julia W. Joiner</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Kent Co. Ma.</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles R. Urie</u> (Address) <u>Rock Hall Ma.</u> | | | |
| 15 Filed <u>3/5</u> , 1914 <u>T. B. Darding</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>March 3</u> , 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY That I attended deceased from <u>March 1</u> , 1914 to <u>March 3</u> , 1914. that I last saw him alive on <u>March 2</u> , 1914. | | | |
| and that death occurred on the date stated above, at <u>4 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Hydrocephalus</u> (Duration) <u>1</u> yrs. <u>—</u> mos. <u>—</u> ds. | | | |
| Contributory (Secondary) (Signed) <u>W. H. Schwartz</u> , M. D. <u>Mar 5th</u> , 1914 (Address) <u>Rock Hall Md.</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>—</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Wesley Chapel Cemetery</u> | | DATE OF BURIAL <u>Mar 5</u> , 1914 | |
| 20 UNDERTAKER <u>Thos H. Casey</u> | | ADDRESS <u>Rock Hall</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

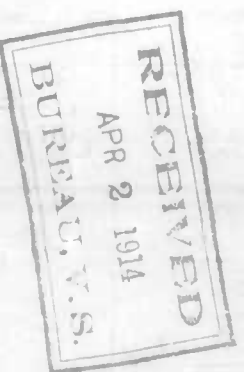
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

oma, Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2978

 STATE OF MARYLAND
 CERTIFICATE OF DEATH
County KentVillage or City Bulls Field Farm, Chestertown (No. 7 Ward)Registration Dist. No. 204

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Virginia May Watson

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
 (Write the word)

 6 DATE OF BIRTH May 4, 1907
 (Month) (Day) (Year)

 7 AGE 6 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

 8 OCCUPATION (a) Trade, profession, or particular kind of work school
 (b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country) Kent Co Md10 NAME OF FATHER Edgar J. Watson11 BIRTHPLACE OF FATHER (State or country) Kent Co Md12 MAIDEN NAME OF MOTHER Priscilla D. Macklin13 BIRTHPLACE OF MOTHER (State or country) Kent Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Watson(Address) Chestertown, 2
 15 Filed May 7, 1914 J. W. Smith
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH March 6, 1914
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1914 to March 6, 1914, that I last saw her alive on March 6, 1914

 and that death occurred on the date stated above, at 12:30 P. M.
 The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis(Duration) 14 yrs. 3 mos. 4 ds.Contributory (Secondary) Tonsillitis(Duration) 3 yrs. 3 mos. 3 ds.
 (Signed) Frank W. Smith, M. D.
March 6, 1914 (Address) Chestertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

 At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Chestertown DATE OF BURIAL Mar. 8, 191420 UNDERTAKER Chas. L. Todd ADDRESS Chestertown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting Y. S. No. 1.

Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

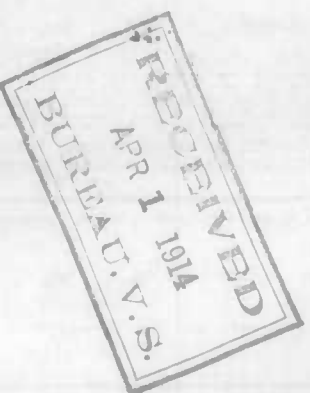
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative sanitary-ness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for every surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Kent

2979

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

Village or City Millington (No. _____, St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Isaac James Wilmer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Not known, 1816
(Month) (Day) (Year)

7 AGE 68 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (State or country) Not known

12 MAIDEN NAME OF MOTHER Charity Frisby

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Conyers

(Address) Millington Md.

15 Filed 3/24/14 1914 Juliant Pomeroy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 23rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1913, to March 23, 1914, that I last saw him alive on March 23, 1914

and that death occurred on the date stated above, at 6¹⁰ A. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Contributory (Secondary) Cerebral Apoplexy, (Duration) 5 yrs. _____ mos. _____ ds.

(Signed) J. Herbert Bates, M. D. (Duration) _____ yrs. _____ mos. _____ ds. 4 hrs
3/24, 1914 (Address) Millington Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Millington 3 20, 1914

20 UNDERTAKER

ADDRESS

John L. Smith Millington Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

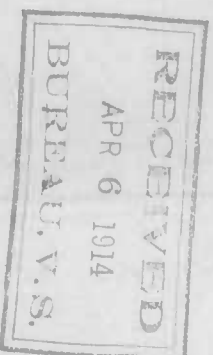
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 22 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2980

 154
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
County KentRegistration Dist. No. 200Village or City Millington (No. _____ St.; _____ Ward)
 [If death occurred in
 a hospital or institution,
 give its NAME instead
 of street and number.]

2 FULL NAME

Washington La Fayette Woodall

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
6 DATE OF BIRTH Sept 12 1836
 (Month) (Day) (Year)7 AGE 77 yrs. 6 mos. 3 ds. It LESS than 1 day, ____ hrs. OR ____ min. ?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work Retired Steamboat Captain
 (b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER John Woodall11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Sarah Graham13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Washington Woodall(Address) Millington

15

 Filed MAR 17 1914 Julian D. Poirer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17 1914
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from March 6 1914 to March 17 1914,
 that I last saw him alive on March 16 1914
and that death occurred on the date stated above, at 12:30 A. M.

The CAUSE OF DEATH* was as follows:

Senile debility

Contributory (Secondary)

Pulmonary (Duration) ____ yrs. ____ mos. 14 ds.
 (Signed) Herbert Gates M. D.
3/17/14, 1914. (Address) Millington, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Christiansburg Md 3 19, 1914

20 UNDERTAKER

ADDRESS

John S. Smith Millington

If more blanks are needed, address State Registrar, 6 E. Franklin St. Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative *causal* truthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—"oil mine," etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantison," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2981

County KentSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 202Village or City near Melilot (No. Station 3 St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nelson Virginia Younger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Sept 12, 1913
(Month) (Day) (Year)

7 AGE

1 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Kent - Corn

PARENTS

10 NAME OF FATHER

Romer Younger

11 BIRTHPLACE OF FATHER

(State or country)

Kent - Corn

12 MAIDEN NAME OF MOTHER

Mabel Beck

13 BIRTHPLACE OF MOTHER

(State or country)

Kent - Corn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. J. Beck

(Address)

Boylan # 3

15

Filed

Mar 23, 1914W. H. Hicks
Local

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 27, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from March 12, 1914, to March 21, 1914.that I last saw her alive on March 21, 1914.and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(Duration) yrs. mos. 12 ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Frauncey Smith; M. D.March 12, 1914 (Address) Chestertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wesley Chapel R.C. Ch. March 23, 1914

20 UNDERTAKER

ADDRESS

Thomas L. Loda Chestertown

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